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| **Preadmission Screen and Resident Review**  **Comprehensive Evaluation**  **For Serious Mental Illness and Intellectual Disability/Related Condition** | | | | | |
| **Section 1: Referral Info** | | **Date of Referral:** | | **Date Assigned to PASRR Staff:** | |
| **CMHC** **Region Completing Assessment:** | | | | **Name of Evaluator:** | |
| **Applicant’s Name:** | | | | **Social Security Number:** | |
| **Birth Date:** | | **Gender:** | **Marital Status:** | **Spouse:** | |
| **Evaluation Location:**   Own Home  Relatives Home  Hospital  Psych Hosp/ Unit  SCL Service Site  ICF/IID  Nursing facility  Personal or Family Care Home  Other | | | | | |
| **Referral Source**:  KLOCS LOC Recommendation  KLOCS Request Level II  MAP 409  MAP 4095 | | | | | |
| |  |  | | --- | --- | | **Legal Guardian:**  Yes  No | **POA or other legal representative:**  Yes  No | | | | | | |
| Name: | | | | | |
| Relationship to Applicant: | | | | | Telephone: |
| **Facility Requested:** | | | | | Region NF located: |
| Address: | | | | | City/State: |
| Contact Person: | | | | | Telephone: |
| Name of admitting physician to receive Summary of Findings: | | | | | Address: |
| **Type of Referral:**  (based on Level I) | Mental Illness | | Intellectual Disability | | Related Condition |
|  | | | | | Dual Diagnosis |
| **Type of Assessment:** (Check One) | | | | | |
| **Preadmission** | | **Initial Resident Review** | | | **Subsequent Review** |
| Applicant new to nursing facility or returning from lower level of care. | | Hospital Exemption | | | Significant Change In Condition |
| **Provisional Admission** | | |  |
| Respite | | |  |
| Delirium | | |  |
| **Give Date of Nursing Facility Admission (If evaluation or referral was late, explain here):** | | | | | |

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| --- | --- | --- |
| **Information for this evaluation was obtained from the following: (List PERSON/ AGENCY/ DATE of CONTACT)**  *\*Be sure to reach out to any relevant agency mentioned by the individual/guardian/family, or found in records obtained.* | | |
|  | Applicant (If applicant was unable to significantly contribute to the interview, please identify reason): |
|  |  |
|  | Family Members / Legal Representative: |
|  |  |
|  | Other Agencies: |
|  |  |
|  | Record / Document Review : |
|  |  |

**Section 2: Diagnosis and Testing**

|  |  |  |
| --- | --- | --- |
| **Mental/Behavioral Health** | **Intellectual Disability and/or Related Condition** | **Medical (other medical Dx that do not fit into SMI, ID, or RC categories)** |
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| --- | --- | --- | --- | --- |
|  | **Score/Rating** | **Tools used for Assessment** | **Evaluator** | **Date** |
| **IQ** |  |  |  |  |
| **Adaptive Behavior** |  |  |  |  |
| **Other** |  |  |  |  |
| **Other** |  |  |  |  |
| Comments: (Provide details about known testing (when/where) and attempts to get the records if testing was not obtained.) | | | | |

**Current history and physical shall be attached. If there has been no significant change in the individual’s medical condition, a copy of a history/physical performed by a physician within the last year may be used and attached. The history and physical must reflect the individual’s current condition. If the physical conducted by an APRN, PA, or RN, a physician’s signature is required.**

**Section 3: Medication History**

|  |
| --- |
| **List or attach copy of current medications and reason for use:** |
| **Allergies:** |
| **Documentation of all other medications individual has taken in the last year if known:** |
| **Previous psychotropic medications (Please include dosage, frequency and reason):** |
| **Comment on any medications that could mask or mimic mental illness symptoms:** |
| **Does/has the client use (d) alcohol or other substances? Has their alcohol usage and/or substance usage resulted in the need for treatment; resulted in involvement from law enforcement; caused financial woes; or had any other negative impacts?** (If yes – provide details including type, frequency, amount and length of use/abuse, and how this has affected their lives) |
| **Does client complain of side effects of medication, or are there visible signs of side effects?** |
| **Self-Management of medications:**  Independent  Refuses Medication  Takes other than as prescribed  With prompting and supervision  Hoards Medication |
| **Comments:** (explain specific individual’s needs and/or limitations) |

|  |
| --- |
| **Section 4: Mental Health Status / Psychiatric Assessment** |
| **Treatment Review** |
| Psychiatric Hospitalization: Prior admission to state or private psychiatric facilities (give dates, facility and reason for admission) |
| Community-Based Treatment: Involvement with community mental health center, private psychiatric or other treatment facilities (include outpatient and community support services, dates of services, provider, reason and outcome) |
| History of engagement/success with recommended treatment: |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Mental Status Assessment** | | | | | | | | |
|  |  | **Yes** | **No** |  | | **Yes** | **No** |
| Orientation | Person  Place  Time  Situation |  |  | Attitude | Cooperative  Guarded  Withdrawn  Hostile |  |  |
| Appearance | Clean  Neat  Unkempt  Disheveled  Unusual dress  Normal eye contact  Intense eye contact  Poor/no eye contact |  |  | Memory/ Cognitive Perform-ance | Immediate intact  Short term intact  Long term intact  Distractible/inattentive  Slow processing  Impaired judgment  Limited awareness |  |  |
| Mood | Euthymic  Irritable  Elevated  Depressed  Anxious  Labile |  |  | Speech | Clear  Slurring  Incoherent  Slowed  Pressured  Loud  Soft  Excessive  Minimal  Nonverbal |  |  |
| Affect | Normal/congruent  Inappropriate/incongruent  Constricted  Flat |  |  |
| Psychomotor  /Mobility | Normal  Slowed  Involuntary movement/tics  Compulsive/Repetitive behaviors/fidgeting  Normal posture  Rigid  Slumped |  |  | Thought content/ processing | Goal directed and logical  Disorganized  Hallucinating (visual, auditory, tactile)  Paranoid  Delusional  Grandiose  Obsessive thoughts  Tangential |  |  |
| Communica-tion method | Verbal  Sign language  Gestures  Typing/handwriting  Pictures/electronic device  Lip reading  Interpreter  Braille |  |  | Danger to self/ others | Suicidal ideation   * Without plan * With plan   Homicidal ideation   * Without plan * With plan   Other (explain in comments) |  |  |
| Comments or additional observations: | | | | | | | | |

**Section 5: Activities of Daily Living**

Please rank the person’s ability to perform the following: (Current functioning levels 1-5)

**(1) Independent (2) needs reminders (3) needs supervision (4) needs partial physical support (5) needs full physical support**

**Description of assistance should explain the individual’s specific needs and/or deficits.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **LEVEL** | **Description of assistance** |  | **LEVEL** | **Description of assistance** |
| Ambulation |  |  | Dressing |  |  |
| Maintain balance |  |  | Bathing |  |  |
| Getting in/out of tub |  |  | Hygiene |  |  |
| Getting on/off toilet |  |  | Mealtime/eating |  |  |
| Change position in bed |  |  | Dietary restrictions |  |  |
| Transfer |  |  | Health monitoring |  |  |
| Meal preparation |  |  | Shopping |  |  |
| Light housekeeping |  |  | Travel |  |  |
| Heavy housekeeping |  |  | Laundry |  |  |
| Money management |  |  |  |  |  |

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| **Vision** |
| No deficits  Wears Glasses/Contacts:  Needs Glasses/contacts:  Corrective surgery:  Cataract:  Glaucoma:  Legally Blind/Some vision:  Blind/No vision: |
| Comment: |
| **Hearing** |
| No deficits:  Hard of Hearing:  Hearing Aid:  Cochlear Implant:  Deaf: |
| Comment: |
| **Language** |
| Preferred language: |
| Is English the primary Language used/understood  Yes  No |
| Comments: (include, in detail, what the individual needs to communicate more effectively) |

|  |
| --- |
| **Physical Therapy** Receives  Y  N Recommended for  Y  N |
| **Occupational Therapy** Receives  Y  N Recommended for  Y  N |
| **Swallow Study** Received  Y  N Recommended for  Y  N |
| **Speech/Language Therapy** Receives  Y  N Recommended for  Y  N |
| **Hearing screen recommendation:**  Y  N |
| **Comments:** (include in detail the individual’s needs and/or deficits as they relate to the recommendations) |

**Section 6: Psychosocial Evaluation**

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| --- |
| Reason for Placement: (Identify changes in the individual’s status and/or living situation that contributed to the referral for NF placement) |
| Is placement in nursing facility considered temporary:  Yes  No |
| What barriers may prevent the return to Community Services: (what services or supports are needed to help this individual transition into the community?) |
| Family/Friends/Support System (list names, relationships, and phone numbers) |
| Current Functioning Level (ability of person to function independently or with supports): |

|  |
| --- |
| **Social/behavioral** |
| **Social skills/participation** *(check all that apply)* |
| Initiates social interactions  Does not initiate but participates if others initiate  Does not participate in social interactions  Avoids social interactions  Inappropriate response/behaviors during social interactions (describe in comments)  Experiences anxiety in unfamiliar social situations/settings |
| Comments: (additional social functioning information) |
| Family history and current relationships: |
| Hobbies/activities: |
| **Emotion/behavior regulation** *(Check all that apply)* |
| Utilizes coping skills to manage emotions:  independently  with minor supports  with significant supports  does not manage emotions  recognizes/correctly identifies emotions  Hx of self-injurious behavior  Hx of aggression toward others: physical aggression  threats of physical harm  property damage |
| Comments: (additional emotional/behavioral functioning information) |
| Legal status (charges, probation/parole, offender registries): |
| Identify any supports/techniques used and outcome: |
| Give any developmental history that would provide insight to behaviors or diagnosis (legal trouble, psychological trauma, abuse, experiences, developmental milestones, and how the individual functioned in childhood in relation to school, friends, personality and hobbies, etc… Gather all known history from the individual/guardian/family. ): |

|  |  |
| --- | --- |
| **ID/RC service history –**  If no indication of ID/RC check here  and continue to Educational history, otherwise complete this section. | |
| Have supports been provided in another State, Region?  Yes  No | |
| If so – what, where, and when: | |
| **Currently Receives ID Services:**  Yes  No | **If not, did they receive ID Services in the past:** ☐ Yes ☐ No |
| SCL waiver  MPW waiver  HCB waiver  SGF  MFP | |
| ICF/IID  Other ID services  Specialized Services | |
| **ID Service** **Providers** | |
| Case Management Agency: | |
| Residential support agency: | |
| Other: | |

|  |
| --- |
| **Educational History** *(Check all that apply)* |
| No Formal Education  Attended School ……...If marked, highest grade completed:  “Dropped Out” …..… If marked, date and reason for leaving:  Special Education …….. If marked, what category:  Completed High School ……..If marked, type of certification/diploma:  Vocational school/College  …..If marked, provide detail: |
| Details (specialized school, home school, academic performance, repeated grades, were there any discipline problems, repeated absences, etc… Include reasons for no schooling or dropping out as applicable.): |

|  |
| --- |
| **Employment History** *(Check all that apply)* |
| Currently employed ................With supports  Without supports |
| Previously employed................With supports  Without supports |
| No work history |
| Desires to Work  If so, degree and intent of supervision/supports needed: |
| Military Service Yes No Number of years :       Type of discharge: |
| Details (such as length of employment, barriers to employment, job performance, type of employment, have they been fired and why, etc.…. Include reasons for no employment as applicable): |

**Section 7: Review of Findings**

**Low Intensity Medicaid Nursing Facility Level of Care**

In order to meet minimal level of care criteria for admission to a nursing facility, an applicant **must** meet two (2) criteria listed below. **(Check the box(s) that apply)**

|  |  |
| --- | --- |
|  | Assistance with personal care |
|  | Assistance with transfer or propelling wheelchair |
|  | Physical or environmental management for confusion and mild agitation |
|  | Must have assistance and be present during entire meal time |
|  | Physical assistance with going to the bathroom or using bedpan for elimination |
|  | Existing Colostomy Care |
|  | In-dwelling catheter for dry care |
|  | Changes in bed position |
|  | Administration of stabilized dosages of medication |
|  | Restorative and supportive nursing care to maintain the individual and prevent deterioration of the individual’s condition |
|  | Administration of injections during time licensed personnel is available |
|  | Routine administration of oxygen after a regimen of therapy has been established |

**Patient Status: (Previously level of care)**

Per 907 KAR 1:022, patient status (LOC) decision shall be based on medical diagnosis, care needs, services and health personnel required to meet these needs and the feasibility of meeting the needs through alternative institutional or non-institutional services.

Persons who meet Nursing Facility Level of Care, and whose support needs do not exceed what can be provided in a facility, have the right to receive their supports in a Nursing facility, if their placement does not endanger themselves or others.

An alternative setting in the community may be less restrictive, and recommended, but the decision is with the individual and guardian if applicable. When placement options and supports are discussed with the individual and guardian, full disclosure of their options is required.

**Community options discussed with individual/guardian:**

Yes – what was discussed:

No – explain why options were not discussed:

|  |
| --- |
| **Individual’s Strengths and Weaknesses** (include details about the individual’s capabilities): |
| **Nursing Facility Care Needs** (As applicable, include details about the individual’s inability to participate in specialized services)**:** |
| **Behavioral Health services to be included in the resident’s treatment plan while residing in the nursing facility.**  (Clearly describe behavioral health services needed and how they will benefit the individual): |
| **Does the individual have a Neurocognitive Disorder Diagnosis (i.e. Dementia, Alzheimer’s…)?**  Y  N  **If yes, explain whether the PASRR Dx (SMI, ID or RC) or the Neurocognitive Dx is primary and why:** |

**Specialized Services**

For Serious Mental Illness: Service needs are the implementation of an individualized plan of care developed under and supervised by a physician, and provided by an interdisciplinary team of qualified mental health professionals that prescribes specific therapies and activities for the treatment of persons who are experiencing an acute episode of serious mental illness, which necessitates continuous supervision by trained mental health personnel. If an individual’s needs cannot be met through these services, the individual may require specialized services through inpatient psychiatric care.

For Intellectual Disability/Related Condition: Specialized Services means the continuous, aggressive and consistent implementation of a program of specialized and generic training, treatment, and health related services, which are comparable to those provided in an intermediate care facility for individuals with intellectual disabilities (ICF/IID), or in a community-based waiver program that provides services to persons with intellectual or other developmental disabilities. SS exceed the services ordinarily provided by the NF under its per diem rate. Specialized services are provided in the NF or off-site. They should be directed toward:

a) The acquisition of the skills necessary for the person to function with as much self-determination and independence as possible;

b) The prevention or deceleration of regression or loss of current optimal functional status; and

c) The coordination and interaction, at all times and in all settings, of all staff and the individual served, in the implementation of the specified plan of care objectives for the individual.

**The need and intensity of specialized services are based on determining an individual’s inability to:**

* Take care of most personal care needs;
* Understand simple commands;
* Communicate basic needs and wants;
* Be employed at a productive wage level without systematic long-term supervision or support;
* Learn new skills without aggressive and consistent training;
* Apply skills learned in a training situation to other environments or settings without aggressive consistent training;
* Demonstrate behavior appropriate to the time, situation, or place without direct supervision;
* Make decisions requiring informed consent without extreme difficulty.

In addition to the above criteria, demonstrated severe maladaptive behavior(s) that place the person’s or others’ health and safety in jeopardy would necessitate the availability of trained ID/RC personnel to teach the person functional skills.

|  |  |
| --- | --- |
| **Important to the person**  (Include what the person says, has said or indicated with their words or behaviors, those things considered essential to a comfortable and satisfying life. What are their hobbies, interest, passions, etc.? What is important to them?)    Is this available in the Nursing Facility:  Y  N  Based on what is important to them, provide details on how this can be achieved including specific measures, persons, frequency, duration, location, or contact information. For specialized services, focus on the individual maintaining skills, learning a skill, increasing independence, and/or integrating into the community: | **Important for the person**  (Include those things to keep in mind regarding health, safety and prevention of regression or loss of skills which could become a barrier to community based services)    Is this available in the Nursing Facility:  Y  N  Based on what is important for them, provide details on how this can be achieved including specific measures, persons, frequency, duration, location, or contact information. For specialized services, focus on the individual maintaining skills, learning a skill, increasing independence, and/or integrating into the community: |
| **Important to the person**  (Include what the person says, has said or indicated with their words or behaviors, those things considered essential to a comfortable and satisfying life. What are their hobbies, interest, passions, etc.? What is important to them?)    Is this available in the Nursing Facility:  Y  N  Based on what is important to them, provide details on how this can be achieved including specific measures, persons, frequency, duration, location, or contact information. For specialized services, focus on the individual maintaining skills, learning a skill, increasing independence, and/or integrating into the community: | **Important for the person**  (Include those things to keep in mind regarding health, safety and prevention of regression or loss of skills which could become a barrier to community based services)    Is this available in the Nursing Facility:  Y  N  Based on what is important for them, provide details on how this can be achieved including specific measures, persons, frequency, duration, location, or contact information. For specialized services, focus on the individual maintaining skills, learning a skill, increasing independence, and/or integrating into the community: |

**Section 8: Determination**

**Does the individual meet PASRR criteria:**

**YES** – the individual does meet PASRR criteria for:

ID/RC

SMI

Dual

Was referred as a Dual evaluation but only met for  ID/RC  SMI. Did not meet  ID/RC  SMI criteria because:

**AND:** (must mark one)

Meets Medicaid level of care and does not require specialized services.

Total care needs can be met in the nursing facility.

Meets Medicaid level of care, but requires additional or specialized services in the nursing facility.

Does not meet Medicaid level of care.

No longer meets Medicaid level of care.

(Does 30 month option apply?)  Yes  No

**NO** – the individual does not meet PASRR criteria because: (must mark one)

*\* A response to referral must be completed*

The individual was found to not have SMI, ID, or RC

There was not sufficient evidence to support the diagnosis of SMI, ID, or RC

The individual has a primary diagnosis of dementia (including Alzheimer’s disease or a related disorder).

Provide details on how you reached the determination that the individual did not meet PASRR criteria (**REQUIRED**):

**Evaluation Time Frames:**

Date of Referral:

**Signature of Evaluator: \_**     **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Title: \_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:

**Counter Signature: \_**     **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Title: \_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:

|  |  |  |  |
| --- | --- | --- | --- |
| **INTERPRETATION OF PASRR FINDINGS:** | | | |
| |  | | --- | | The Center for Medicare and Medicaid Services (CMS) regulations mandate that the findings of this evaluation be interpreted to: the individual, the legal guardian, or for a legally competent person who is incapable of understanding the findings, to his/her designated family member or representative. These findings must be explained AFTER a final determination has been made by the PASRR committee (as applicable). | | The findings and recommendations of this evaluation have been explained to (check one): | | Individual  Legal Guardian  Representative | |  |   I understand that my signature does not represent my consent or agreement with the findings. I also understand that I have the right to contest the findings if I receive a determination that I do not require nursing facility level of care or that I do not need specialized services. A cover letter accompanying this evaluation explains my appeal rights. | | | |
|  |  |  |
| Individual /Guardian/ Representative |  | (Relationship, if appropriate) |

Community Mental Health Center Staff/Title \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NOTE:** If signature was not obtained, please document steps taken to obtain signature and note the date the Interpretation of Findings was sent to the individual/representative.

**Reason for no signature from individual/guardian/representative**:

**Witness Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date final report sent to all appropriate parties:**